SERFF Tracking Number:	*UTAC-125786706*	*State:*	*Arkansas*
Filing Company:	*United Teacher Associates Insurance Company*	*State Tracking Number:*	*40027*
Company Tracking Number:	*CF96APP-UTA.V2*		
TOI:	*H07I Individual Health - Specified Disease - Limited Benefit*	*Sub-TOI:*	*H07I.002A Dread Disease - Cancer Only*
Product Name:	*Cancer Application*		
Project Name/Number:	*/*		

Filing at a Glance

Company: United Teacher Associates Insurance Company

Product Name: Cancer Application	SERFF Tr Num: UTAC-125786706	State: ArkansasLH
TOI: H07I Individual Health - Specified Disease - Limited Benefit	SERFF Status: Closed	State Tr Num: 40027
Sub-TOI: H07I.002A Dread Disease - Cancer Only	Co Tr Num: CF96APP-UTA.V2	State Status: Approved-Closed
Filing Type: Form	Co Status:	Reviewer(s): Rosalind Minor
	Authors: Joyce Kostakis, Melissa MacLaurin	Disposition Date: 08/27/2008
	Date Submitted: 08/25/2008	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name:	Status of Filing in Domicile: Not Filed
Project Number:	Date Approved in Domicile:
Requested Filing Mode:	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Group Market Size:
Overall Rate Impact:	Group Market Type:
Filing Status Changed: 08/27/2008	
State Status Changed: 08/27/2008	Deemer Date:

Corresponding Filing Tracking Number:

Filing Description:

Re: UNITED TEACHER ASSOCIATES INSURANCE COMPANY; NAIC # 63479; FEIN # 58-0869673

NEW POLICY FORM#	DESCRIPTION
CF-960201-UTA-APP.V2	Application for First Diagnosis Cancer Benefit

SERFF Tracking Number:	*UTAC-125786706*	*State:*	*Arkansas*
Filing Company:	*United Teacher Associates Insurance Company*	*State Tracking Number:*	*40027*
Company Tracking Number:	*CF96APP-UTA.V2*		
TOI:	*H07I Individual Health - Specified Disease - Limited Benefit*	*Sub-TOI:*	*H07I.002A Dread Disease - Cancer Only*
Product Name:	*Cancer Application*		
Project Name/Number:	*/*		

CT-95-UTA-APP-V2 Application for Cancer Treatment Benefit

FOR USE WITH APPROVED POLICY:

APPROVED FORM:	DESCRIPTION	APPROVED
CF-960201-UTA-AR	First Diagnosis Cancer Benefit Policy	11/10/1999
CT-950102-UTA-AR	Cancer Treatment Benefit Policy	9/24/2004

Dear Analyst,

I am submitting for review and approval the applications described above. We will be using the applications to solicit the Cancer Insurance products referenced above. The Application for First Diagnosis Cancer Benefit will be used with the previously approved First Cancer Benefit Policy. The Application for Cancer Treatment Benefit will be used with the approved Cancer Treatment Policy. The applications are new and are not intended to replace any forms currently in use.

Attached please find a final copy of the applications as well as a statement of variability. The variable fields in the application are dependent on which one of our distribution groups will be marketing the base product. For example, we have a distribution group that markets to seniors only and will not offer the First Diagnosis Heart Attack Rider as the issue ages are limited to ages 0-69. With this distribution group we will remove the First Diagnosis Heart Attack & First Major Heart Surgery Rider from the application. We will use the same application form number, but will reflect the distribution group on the lower right corner of the application such as 08/08 Senior Market. In addition to noting the riders as variable, we have marked the verbiage "these riders" as variable so we can change them to "this rider" when the First Diagnosis Heart Attack rider is removed from the application.

We look forward to your review and approval. Should you have any questions, or need further information, please do not hesitate to contact me at (800) 880-8824 x4794, mmaclaurin@gafri.com or via facsimile at (512) 451-0357. Thank you for your time and consideration with our submission.

Sincerely,

Melissa MacLaurin, Compliance Analyst
Compliance Department

SERFF Tracking Number:	*UTAC-125786706*	*State:*	*Arkansas*
Filing Company:	*United Teacher Associates Insurance Company*	*State Tracking Number:*	*40027*
Company Tracking Number:	*CF96APP-UTA.V2*		
TOI:	*H07I Individual Health - Specified Disease - Limited Benefit*	*Sub-TOI:*	*H07I.002A Dread Disease - Cancer Only*
Product Name:	*Cancer Application*		
Project Name/Number:	*/*		

Company and Contact

Filing Contact Information

Melissa MacLaurin,
11200 Lakeline Blvd Ste 100
Austin, TX 78717

mmaclaurin@gafri.com
(512) 807-4794 [Phone]

Filing Company Information

United Teacher Associates Insurance Company
11200 Lakeline Blvd., Suite 100

P.O. Box 26580
Austin, TX 78755-0580
(800) 880-8824 ext. [Phone]

CoCode: 63479
Group Code: 84

Group Name:
FEIN Number: 58-0869673

State of Domicile: Texas
Company Type: Insurance Company

State ID Number:

Filing Fees

Fee Required?	Yes
Fee Amount:	$40.00
Retaliatory?	No
Fee Explanation:	$ 20.00 per form
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
United Teacher Associates Insurance Company	$40.00	08/25/2008	22103781

SERFF Tracking Number:	*UTAC-125786706*	*State:*	*Arkansas*
Filing Company:	*United Teacher Associates Insurance Company*	*State Tracking Number:*	*40027*
Company Tracking Number:	*CF96APP-UTA.V2*		
TOI:	*H07I Individual Health - Specified Disease - Limited Benefit*	*Sub-TOI:*	*H07I.002A Dread Disease - Cancer Only*
Product Name:	*Cancer Application*		
Project Name/Number:	*/*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	08/27/2008	08/27/2008

SERFF Tracking Number:	*UTAC-125786706*	*State:*	*Arkansas*
Filing Company:	*United Teacher Associates Insurance Company*	*State Tracking Number:*	*40027*
Company Tracking Number:	*CF96APP-UTA.V2*		
TOI:	*H07I Individual Health - Specified Disease - Limited Benefit*	*Sub-TOI:*	*H07I.002A Dread Disease - Cancer Only*
Product Name:	*Cancer Application*		
Project Name/Number:	*/*		

Disposition

Disposition Date: 08/27/2008
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*UTAC-125786706*	*State:*	*Arkansas*
Filing Company:	*United Teacher Associates Insurance Company*	*State Tracking Number:*	*40027*
Company Tracking Number:	*CF96APP-UTA.V2*		
TOI:	*H07I Individual Health - Specified Disease - Limited Benefit*	*Sub-TOI:*	*H07I.002A Dread Disease - Cancer Only*
Product Name:	*Cancer Application*		
Project Name/Number:	*/*		

Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	STATEMENT OF VARIABILITY	Approved-Closed	Yes
Form	First Diagnosis Cancer Application	Approved-Closed	Yes
Form	Cancer Treatment Application	Approved-Closed	Yes

SERFF Tracking Number:	*UTAC-125786706*	*State:*	*Arkansas*
Filing Company:	*United Teacher Associates Insurance Company*	*State Tracking Number:*	*40027*
Company Tracking Number:	*CF96APP-UTA.V2*		
TOI:	*H07I Individual Health - Specified Disease - Limited Benefit*	*Sub-TOI:*	*H07I.002A Dread Disease - Cancer Only*
Product Name:	*Cancer Application*		
Project Name/Number:	*/*		

Form Schedule

Lead Form Number: CF96APP-UTA.V2

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	CF96APP-UTA.V2	Application/ Enrollment Form	First Diagnosis Cancer Application	Initial			CF96APP-UTA.V2 rev 08-08.pdf
Approved-Closed	CT95APP-UTA.V2	Application/ Enrollment Form	Cancer Treatment Application	Initial			CT95APP-UTA.V2 rev 8-08.pdf

UNITED TEACHER ASSOCIATES INSURANCE COMPANY

[P.O. BOX 26580 • AUSTIN, TEXAS 78755-0580]

APPLICATION FOR FIRST DIAGNOSIS CANCER BENEFIT POLICY

☐ **New Business** ☐ **Reinstatement** ☐ **Benefit Change** PV Case#_____

County Name:		County Number:		Date of Birth Month	Day	Year	Sex	Height	Weight
Applicant:									
Spouse:								**X**	**X**
Child #1:								Full Time Student?	☐ Yes ☐ NO
Child #2:								Full Time Student?	☐ Yes ☐ NO
Child #3:								Full Time Student?	☐ Yes ☐ NO

Applicant's Address:		City:		State:		Zip Code:	
Payer's Name:		Relationship:		Payer's Address:			
Applicant's Social Security # :				Occupation:			
Beneficiary (full name):		Relationship:		Job Duties:			
Employer's Name:				Employer's Address:			
Home telephone # :	( )	Work telephone # :	( )	Best time to call			

☐ Individual ☐ Single Parent ☐ Family	Premium Payment Mode:	
First Diagnosis Cancer Benefit Policy Benefit Amount: $	Modal Premium	$
☐ *Intensive Care Unit Benefit Rider* Benefit Amount: **$** per day	Rider Premium	$
☐ [*Return of Premium Rider]*	Rider Premium	$
☐ [*First Diagnosis Heart Attack & First Major Heart Surgery Rider]* [Benefit Amount:] **$**	Rider Premium	$
☐ [***Other]*** Specify rider type and benefit amount (if applicable:)	Rider Premium	$

FOR PAYROLL DEDUCTION:

Group Name:				Enrollment Fee	$
Group Number:		Is this Section #125?	☐ Yes ☐ No	TOTAL PREMIUM	$

1. Is the insurance applied for here intended to replace any existing insurance? ☐ Yes ☐ No
   If yes, list name of Company and policy number: _____

MEDICAL INFORMATION. Answer all questions and circle the applicable conditions.

2. Have you or any person to be insured under this policy ever had a test to determine if cancer is present where the results are pending or are other than normal? If Yes, who?_____ **Please describe the results**. ☐ Yes ☐ No

3. Have you or any person to be insured under this policy ever been treated for or had symptoms of Internal Cancer, Melanoma, Malignant Growth, Sarcoma, or any type of Cancer, except non-melanoma skin cancer or had elevated PSA levels greater than 4.0? ☐ Yes ☐ No
   If Yes, who? _____ **If the answer is Yes, any individual named will be excluded from coverage.**

4. Have you or any person to be insured under this policy ever been treated for or had symptoms of Skin Cancer, excluding Melanoma? If Yes, who? _____ **Please describe the condition and treatment period.** ☐ Yes ☐ No

5. Have you or any person to be insured under this policy ever been treated for or had symptoms of Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or tested positive on an AIDS-related (Human Immunodeficiency Virus "HIV") blood test? If "Yes", who? _____ **If the answer is Yes, any individual named will be excluded from coverage under this policy.** ☐ Yes ☐ No

6. Have you or any person to be insured under this policy ever been treated for or had symptoms of Dysplasia of the uterus? _____Please describe the level diagnosed. ☐ Yes ☐ No

PLEASE ANSWER QUESTIONS #7 & #8 IF YOU ARE APPLYING FOR THE INTENSIVE CARE UNIT BENEFIT RIDER:

7. Have you or any person to be insured under the Intensive Care Unit Benefit Rider ever been treated for or had symptoms of diabetes or any disorder, abnormality or condition of the brain, lung, liver, or connective tissue? ☐ Yes ☐ No
   If Yes, who? _____ **If the answer is Yes, any individual named will be excluded from coverage under this rider.**

8. Are you or any person to be insured under the Intensive Care Unit Benefit Rider currently pregnant? If Yes, who? ☐ Yes ☐ No
   _____ **If the answer is Yes, any individual named will be excluded from coverage under this rider.**

PLEASE ANSWER QUESTIONS 9–12 IF YOU ARE APPLYING FOR [THE FIRST DIAGNOSIS HEART ATTACK] OR THE INTENSIVE CARE UNIT BENEFIT RIDER[S]:

9. Have you or any person to be insured under [these riders] ever had, ever been treated for, or ever had symptoms of, ever received medical advice for, or taken prescribed medication for uncontrolled high blood pressure? ☐ Yes ☐ No
   If Yes, who? _____ **If the answer is Yes, any individual named will be excluded from coverage under [these riders].**

10. **Have you, or any person to be insured under [these riders] ever had or ever been advised to have: any form of heart surgery, coronary artery surgery, or heart related surgery; or an arteriogram, angioplasty, or pacemaker installed, or within the last 6 months, received medical advice or consultation or had medical tests performed (including those during the course of routine check-ups) where the results were other than normal or are still pending?** ☐ Yes ☐ No
    If Yes, who? _____ **If the answer is Yes, any individual named will be excluded from coverage under [these riders].**

11. Have you, or any person to be insured under [these riders] ever had, ever been treated for, ever had symptoms of, ever received medical advice for, or ever taken prescribed medication for any disease, disorder or abnormality of the heart or circulatory system (arteries, veins, lymphatic nodes and vessels)? If Yes, who? _____ ☐ Yes ☐ No
    If the answer is Yes, any individual named will be excluded from coverage under [these riders].

12. Have you, or any person to be insured under [these riders] ever had, ever been treated for, ever had symptoms of, ever received medical advice for, or ever taken prescribed medication for: myocardial infarction or heart attack, stroke or transient ischemic attack (TIA)? If Yes, who? _____ ☐ Yes ☐ No
    If the answer if Yes, any individual named will be excluded from coverage under [these riders].

I hereby represent that the foregoing answers are recorded as given by me and that the same are true. I represent that all questions on this application were asked and that the answers were properly recorded. I further agree that this insurance applied for shall be subject to the conditions and provisions of the policy and shall not be in force until the application is accepted and the policy issued by the Company. I acknowledge receipt of the Outline of Coverage. I authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, or The Medical Information Bureau to release any records concerning me or my health to United Teacher Associates Insurance Company and its reinsurers. This authorization will be valid for 24 months from the date the authorization is signed. No agent has the right to waive the answer to any question in this application, to pass on insurability, to waive any of the Company's rights or requirements, or to make or alter any contract. I agree that this application shall form a part of any policy issued. The undersigned applicant and agent represent that the applicant has read or had read to him the completed application and he realizes any false statement or misrepresentation therein which is material to the risk or hazard assumed may result in a loss of coverage under the policy subject to the Time Limit on Certain Defenses and legal proceedings. A photographic copy of this authorization shall be as valid as the original.

I understand that the "Effective Date" of this policy will be the date recorded on the policy schedule by our office. It is not the date the application was signed. The policy has a 30-day "waiting period" which begins on the "Effective Date" of the policy.

I KNOW THAT ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD AN INSURER SUBMITS AN APPLICATION FOR INSURANCE CONTAINING FALSE OR DECEPTIVE STATEMENTS MAY BE GUILTY OF INSURANCE FRAUD.

Note to Agent: Is replacement of insurance involved? ☐ Yes ☐ No

Signed at _____ Date: _____
(City and state)

[Agent's Signature _____ Writing Number _____] Read and Signed (√) _____
(Applicant's Signature)

[Agent's Printed Name _____ Agent's License Number: _____ Check Block if Agent Family Business ☐]

MEDICARE SUPPLEMENT INSURANCE PRE-AUTHORIZATION AGREEMENT FOR ELECTRONIC FUNDS TRANSFER APPLIES TO:

UNITED TEACHER ASSOCIATES INSURANCE COMPANY - P. O. Box 26580 – Austin, TX 78755-0580

_____

Proposed Insured's Name Policy Number (if Available)

_____

Financial Institution Name and Telephone Number

_____

Financial Institution Address

_____

9 Digit Routing Number Account Number

Requested Withdrawal Date (1st thru 28th): _____

Withdraw Payment: ☐ Monthly ☐ Quarterly ☐ Semi-Annually ☐ Annually

Type of Account:

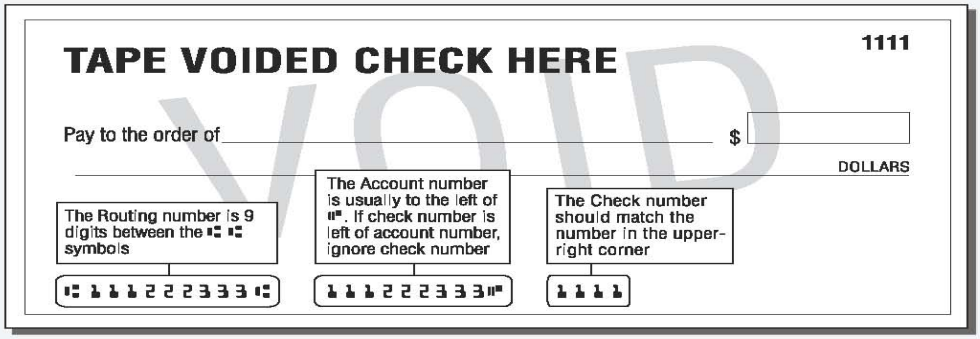
☐ Personal Checking Account
☐ Personal Savings Account
☐ Corporate/Business Checking

Name of Employer Group_____

Purpose for Submitting this Authorization – Check appropriate box(es):

☐ New authorization
☐ Change in checking/savings account
☐ Change in financial institution
☐ Change in existing coverage

Please tape a VOIDED Check (checking account) or Deposit Slip (savings account) in this box.



APPLICANT INFORMATION FOR FINANCIAL INSTITUTIONS: As a convenience to me, I hereby request and authorize you to pay and charge to my account, drafts drawn on my account by and payable to the Company selected above provided there are sufficient funds in said account to pay the same on presentation. Such drafts will bear my printed name. This authorization shall remain in effect until revoked by me in writing, and until you actually receive such notice. I agree that you shall be fully protected in honoring any such draft. I agree that your rights in respect to any such draft shall be the same as if it were a check signed personally by me. I further agree that if any such draft is dishonored, whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

PRE-AUTHORIZATION AGREEMENT FOR ELECTRONIC FUNDS TRANSFER

APPLICANT INFORMATION FOR THE COMPANY SELECTED ABOVE: It is understood that the drafts will be drawn on or about the requested date each month. The presentation of such drafts to the above Financial Institution shall constitute notice of premiums being due upon the contract, and no other notice of premiums due will be given. No premium shall be deemed to have been paid unless and until actual payment of the draft drawn for such premium payment has been received by the selected company above. The cancelled draft will constitute receipt of premium payment. The privilege of paying premiums under this Plan may be revoked by the selected company above if any draft is not paid upon presentation. The payment of premiums under this Plan may be terminated by the Contract Owner, Financial Institution Depositor if other than Contract Owner, or by the company selected above upon 30 days written notice.

X_____

Print Name of Depositor (as it appears on account) Signature of Depositor Date

UNITED TEACHER ASSOCIATES INSURANCE COMPANY

[P.O. BOX 26580 •AUSTIN, TEXAS 78755-0580]

APPLICATION FOR CANCER TREATMENT BENEFIT POLICY

☐ **New Business** ☐ **Reinstatement** ☐ **Benefit Change** PV Case#_____

County Name:		County Number:		Date of Birth Month Day Year			Sex	Height	Weight
Applicant:									
Spouse:								**X**	**X**
Child #1:								Full Time Student	☐ Yes ☐ NO
Child #2:								Full Time Student	☐ Yes ☐ NO
Child #3:								Full Time Student	☐ Yes ☐ NO

Applicant's Address:		City:		State:		Zip Code:	
Payer's Name:		Relationship:		Payer's Address:			
Applicant's Social Security # :				Occupation:			
Beneficiary (full name):		Relationship:		Job Duties:			
Employer's Name:				Employer's Address:			
Home telephone # :	( )	Work telephone # :	( )	Best time to call			

☐ Individual ☐ Single Parent ☐ Family		Premium Payment Mode:	
Cancer Treatment Benefit Policy Daily Hospital Benefit Amount: ☐ $0.00 ☐ $200.00 ☐ $400.00		Modal Premium	$
☐ [*Dread Disease Benefit Rider]*		Rider Premium	$
☐ *Intensive Care Unit Benefit Rider* Benefit Amount: **$**_____ per day		Rider Premium	$
☐ [*Cancer Screening Benefit Rider]*		Rider Premium	$
☐ [*First Diagnosis Heart Attack & First Major Heart Surgery Rider]*	Benefit Amount: **$**_____	Rider Premium	$
☐ [*Return of Premium Benefit Rider*]		Rider Premium	$
☐ [***Other]*** Specify rider type and benefit amount (if applicable:) _____		Rider Premium	$

FOR PAYROLL DEDUCTION:

Group Name:				Enrollment Fee	$
Group Number:		Is this Section #125?	☐ Yes ☐ No	TOTAL PREMIUM	$

1. Is the insurance applied for here intended to replace any existing insurance? If yes, list name of Company and policy number: _____	☐ Yes ☐ No

MEDICAL INFORMATION. Answer all questions and circle the applicable conditions.

2. Have you or any person to be insured under this policy ever had a test to determine if cancer is present where the results are pending or are other than normal? If Yes, who?_____ **Please describe the results**.	☐ Yes ☐ No
3. Have you or any person to be insured under this policy ever been treated for or had symptoms of Internal Cancer, Melanoma, Malignant Growth, Sarcoma, or any type of Cancer, except non-melanoma skin cancer, or had elevated PSA levels greater than 4.0? If Yes, who?_____ **If the answer is Yes, any individual named will be excluded from coverage.**	☐ Yes ☐ No
4. Have you or any person to be insured under this policy ever been treated for or had symptoms of non-melanoma skin cancer? If "Yes", who? _____ **If the answer is "Yes", any individual named will be excluded from all benefits provided by the policy for the treatment of melanoma and skin cancer.**	☐ Yes ☐ No
5. Have you or any person to be insured under this policy ever been treated for or had symptoms of Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or tested positive on an AIDS-related (Human Immunodeficiency Virus "HIV") blood test? If "Yes", who?_____ **If the answer is**	☐ Yes ☐ No
Yes, any individual named will be excluded from coverage under this policy.	

6.	Have you or any person to be insured under this policy ever been treated for or had symptoms of Dysplasia of the uterus? _____Please describe the level diagnosed.	☐ Yes ☐ No

PLEASE ANSWER QUESTIONS #7 & #8 IF YOU ARE APPLYING FOR THE INTENSIVE CARE UNIT BENEFIT RIDER:

7.	Have you or any person to be insured under the Intensive Care Unit Benefit Rider ever been treated for or had symptoms of stroke, heart disease, heart attack or diabetes; or had any other disorder, abnormality or condition of the brain, heart, lung, liver, connective tissue or circulatory system, including the arteries, veins, lymphatic nodes and vessels (but not including high blood pressure, unless controlled? If Yes, who? _____ **If the answer is Yes, any individual named will be excluded from coverage under this rider.**	☐ Yes ☐ No
8.	Are you or any person to be insured under the Intensive Care Unit Benefit Rider currently pregnant? If Yes, who? _____ **If the answer is Yes, any individual named will be excluded from coverage under this rider.**	☐ Yes ☐ No

PLEASE ANSWER QUESTIONS 9–12 IF YOU ARE APPLYING FOR [THE FIRST DIAGNOSIS HEART ATTACK] OR THE INTENSIVE CARE UNIT BENEFIT RIDER[S]:

9.	Have you or any person to be insured under [these riders] ever had, ever been treated for, or ever had symptoms of, ever received medical advice for, or taken prescribed medication for uncontrolled high blood pressure? If Yes, who_____ **If the answer is Yes, any individual named will be excluded from coverage under [these riders].**	☐ Yes ☐ No
10.	Have you, or any person to be insured under [these riders] ever had or ever been advised to have: any form of heart surgery, coronary artery surgery, or heart related surgery; or an arteriogram, angioplasty, or pacemaker installed, or within the last 6 months, received medical advice or consultation or had medical tests performed (including those during the course of routine check-ups) where the results were other than normal or are still pending? If Yes, who? _____ **If the answer is Yes, any individual named will be excluded from coverage under [these riders].**	☐ Yes ☐ No
11.	Have you, or any person to be insured under [these riders] ever had, ever been treated for, ever had symptoms of, ever received medical advice for, or ever taken prescribed medication for any disease, disorder or abnormality of the heart or circulatory system (arteries, veins, lymphatic nodes and vessels)? If Yes, who? _____ **If the answer is Yes, any individual named will be excluded from coverage under [these riders].**	☐ Yes ☐ No
12.	Have you, or any person to be insured under [these riders] ever had, ever been treated for, ever had symptoms of, ever received medical advice for, or ever taken prescribed medication for: myocardial infarction or heart attack, stroke or transient ischemic attack (TIA)? If Yes, who? _____ **If the answer if Yes, any individual named will be excluded from coverage under [these riders].**	☐ Yes ☐ No

[PLEASE ANSWER THE FOLLOWING QUESTION IF YOU ARE APPLYING FOR THE DREAD DISEASE BENEFIT RIDER:

13.	Have you or any person to be insured under the Dread Disease Benefit Rider ever been treated for or had symptoms of one of the following dread diseases: Addison's Disease, Amyotrophic Lateral Sclerosis, Diphtheria, Encephalitis, Epilepsy, Legionnaire's Disease, Lupus Erythematosus or any connective tissue disorder, Meningitis, Multiple Sclerosis, Muscular Dystrophy, Myasthenia Gravis, Niemann-Pick Disease, Osteomyelitis, Poliomyelitis, Rabies, Reye's Syndrome, Rheumatic Fever, Rocky Mountain Spotted Fever, Scarlet Fever, Sickle Cell Anemia, Smallpox, Tay-Sachs Disease, Tetanus, Toxic Epidermal Necrolysis, Toxic Shock Syndrome, Tuberculosis, Tularemia, Typhoid Fever or Whipple's Disease? If Yes, who? _____ For which condition? _____ **If the answer is Yes, any individual named will be excluded from this condition under this rider.]**	☐ Yes ☐ No

I hereby represent that the foregoing answers are recorded as given by me and that the same are true. I represent that all questions on this application were asked and that the answers were properly recorded. I further agree that this insurance applied for shall be subject to the conditions and provisions of the policy and shall not be in force until the application is accepted and the policy issued by the Company. I acknowledge receipt of the Outline of Coverage. I authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, or the Medical Information Bureau to release any records concerning me or my health to United Teacher Associates Insurance Company and its reinsurers. This authorization will be valid for 24 months from the date the authorization is signed. No agent has the right to waive the answer to any question in this application, to pass on insurability, to waive any of the Company's rights or requirements, or to make or alter any contract. I agree that this application shall form a part of any policy issued. The undersigned applicant and agent represent that the applicant has read or had read to him the completed application and he realizes any false statement or misrepresentation therein which is material to the risk or hazard assumed may result in a loss of coverage under the policy subject to the Time Limit on Certain Defenses and legal proceedings. A photographic copy of this authorization shall be as valid as the original.

I KNOW THAT ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD AN INSURER SUBMITS AN APPLICATION FOR INSURANCE CONTAINING FALSE OR DECEPTIVE STATEMENTS MAY BE GUILTY OF INSURANCE FRAUD.

I understand that the "Effective Date" of this policy will be the date recorded on the policy schedule by our office. It is not the date the application was signed. The policy has a 30-day "waiting period" which begins on the "Effective Date" of the policy.

Note to Agent: Is replacement of insurance involved? ☐ Yes ☐ No

Signed at _____ Date: _____
(City and state)

[Agent's Signature _____ Writing Number _____] Read and Signed (√) _____
(Applicant's Signature)

[Agent's Printed Name _____ Agent's License Number: _____ Check Block if Agent Family Business ☐]

MEDICARE SUPPLEMENT INSURANCE PRE-AUTHORIZATION AGREEMENT FOR ELECTRONIC FUNDS TRANSFER APPLIES TO:

UNITED TEACHER ASSOCIATES INSURANCE COMPANY - P. O. Box 26580 – Austin, TX 78755-0580

_____

Proposed Insured's Name Policy Number (if Available)

_____

Financial Institution Name and Telephone Number

_____

Financial Institution Address

_____

9 Digit Routing Number Account Number

Requested Withdrawal Date (1st thru 28th): _____

Withdraw Payment: ☐ Monthly ☐ Quarterly ☐ Semi-Annually ☐ Annually

Type of Account:

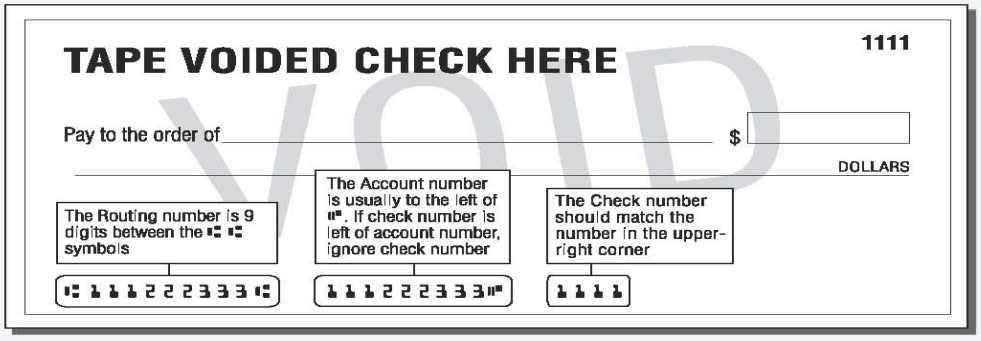
☐ Personal Checking Account
☐ Personal Savings Account
☐ Corporate/Business Checking

Name of Employer Group_____

Purpose for Submitting this Authorization – Check appropriate box(es):

☐ New authorization
☐ Change in checking/savings account
☐ Change in financial institution
☐ Change in existing coverage

Please tape a VOIDED Check (checking account) or Deposit Slip (savings account) in this box.



APPLICANT INFORMATION FOR FINANCIAL INSTITUTIONS: As a convenience to me, I hereby request and authorize you to pay and charge to my account, drafts drawn on my account by and payable to the Company selected above provided there are sufficient funds in said account to pay the same on presentation. Such drafts will bear my printed name. This authorization shall remain in effect until revoked by me in writing, and until you actually receive such notice. I agree that you shall be fully protected in honoring any such draft. I agree that your rights in respect to any such draft shall be the same as if it were a check signed personally by me. I further agree that if any such draft is dishonored, whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

PRE-AUTHORIZATION AGREEMENT FOR ELECTRONIC FUNDS TRANSFER

APPLICANT INFORMATION FOR THE COMPANY SELECTED ABOVE: It is understood that the drafts will be drawn on or about the requested date each month. The presentation of such drafts to the above Financial Institution shall constitute notice of premiums being due upon the contract, and no other notice of premiums due will be given. No premium shall be deemed to have been paid unless and until actual payment of the draft drawn for such premium payment has been received by the selected company above. The cancelled draft will constitute receipt of premium payment. The privilege of paying premiums under this Plan may be revoked by the selected company above if any draft is not paid upon presentation. The payment of premiums under this Plan may be terminated by the Contract Owner, Financial Institution Depositor if other than Contract Owner, or by the company selected above upon 30 days written notice.

X_____

Print Name of Depositor (as it appears on account) Signature of Depositor Date

SERFF Tracking Number:	*UTAC-125786706*	*State:*	*Arkansas*
Filing Company:	*United Teacher Associates Insurance Company*	*State Tracking Number:*	*40027*
Company Tracking Number:	*CF96APP-UTA.V2*		
TOI:	*H07I Individual Health - Specified Disease - Limited Benefit*	*Sub-TOI:*	*H07I.002A Dread Disease - Cancer Only*
Product Name:	*Cancer Application*		
Project Name/Number:	*/*		

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number:	*UTAC-125786706*	*State:*	*Arkansas*
Filing Company:	*United Teacher Associates Insurance Company*	*State Tracking Number:*	*40027*
Company Tracking Number:	*CF96APP-UTA.V2*		
TOI:	*H07I Individual Health - Specified Disease - Limited Benefit*	*Sub-TOI:*	*H07I.002A Dread Disease - Cancer Only*
Product Name:	*Cancer Application*		
Project Name/Number:	*/*		

Supporting Document Schedules

Satisfied -Name: Certification/Notice
Review Status: Approved-Closed 08/27/2008
Comments:
Attachment:
AR Certification.pdf

Bypassed -Name: Application
Review Status: Approved-Closed 08/27/2008
Bypass Reason: SEE FORM SCHEDULE TAB
Comments:

Bypassed -Name: Health - Actuarial Justification
Review Status: Approved-Closed 08/27/2008
Bypass Reason: N/A
Comments:

Bypassed -Name: Outline of Coverage
Review Status: Approved-Closed 08/27/2008
Bypass Reason: N/A
Comments:

Satisfied -Name: STATEMENT OF VARIABILITY
Review Status: Approved-Closed 08/27/2008
Comments:
Attachments:
Cancer First Application statement of variable data.pdf
Cancer Treatment Application statement of variable data.pdf

Arkansas Certification

This submission meets the provisions of Rule and Regulation 19, "Unfair sex discrimination in the sale of insurance" as well as all applicable requirements of this Department.

, Compliance Analyst — August 21, 2008

Name and Title — Date

STATEMENT OF VARIABLE DATA

UNITED TEACHER ASSOCIATES INSURANCE COMPANY

[P.O. BOX 26580 • AUSTIN, TEXAS 78755-0580]

Comment [m1]: Address is variable should the company change addresses in the future.

APPLICATION FOR FIRST DIAGNOSIS CANCER BENEFIT POLICY

☐ **New Business** ☐ **Reinstatement** ☐ **Benefit Change** PV Case#_____

County Name:		County Number:		Date of Birth Month	Day	Year	Sex	Height	Weight
Applicant:									
Spouse:								**X**	**X**
Child #1:								Full Time Student?	☐ Yes ☐ NO
Child #2:								Full Time Student?	☐ Yes ☐ NO
Child #3:								Full Time Student?	☐ Yes ☐ NO

Applicant's Address:		City:		State:		Zip Code:	
Payer's Name:		Relationship:		Payer's Address:			
Applicant's Social Security # :				Occupation:			
Beneficiary (full name):		Relationship:		Job Duties:			
Employer's Name:				Employer's Address:			
Home telephone # :	( )	Work telephone # :	( )	Best time to call			

☐ Individual ☐ Single Parent ☐ Family	Premium Payment Mode:	
First Diagnosis Cancer Benefit Policy Benefit Amount: $	Modal Premium	$
☐ [*Intensive Care Unit Benefit Rider]* Benefit Amount: **$** per day	Rider Premium	$
☐ [*Return of Premium Rider]*	Rider Premium	$
☐ [*First Diagnosis Heart Attack & First Major Heart Surgery Rider]* [Benefit Amount:] **$**	Rider Premium	$
☐ ***Other*** Specify rider type and benefit amount (if applicable:)	Rider Premium	$
FOR PAYROLL DEDUCTION:		
Group Name:	Enrollment Fee	$
Group Number: Is this Section #125? ☐ Yes ☐ No	TOTAL PREMIUM	$

Comment [m2]: Riders are described as variable as we may elect not to offer a rider in the future. We will not add any riders that are not described in this application.

1. Is the insurance applied for here intended to replace any existing insurance? ☐ Yes ☐ No
   If yes, list name of Company and policy number: _____

MEDICAL INFORMATION. Answer all questions and circle the applicable conditions.

2. Have you or any person to be insured under this policy ever had a test to determine if cancer is present where the results are pending or are other than normal? If Yes, who?_____ **Please describe the results**. ☐ Yes ☐ No

3. Have you or any person to be insured under this policy ever been treated for or had symptoms of Internal Cancer, Melanoma, Malignant Growth, Sarcoma, or any type of Cancer, except non-melanoma skin cancer or had elevated PSA levels greater than 4.0? ☐ Yes ☐ No
   If Yes, who? _____ **If the answer is Yes, any individual named will be excluded from coverage.**

4. Have you or any person to be insured under this policy ever been treated for or had symptoms of Skin Cancer, excluding Melanoma? If Yes, who? _____ **Please describe the condition and treatment period.** ☐ Yes ☐ No

5. Have you or any person to be insured under this policy ever been treated for or had symptoms of Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or tested positive on an AIDS-related (Human Immunodeficiency Virus "HIV") blood test? If "Yes", who? _____ **If the answer is Yes, any individual named will be excluded from coverage under this policy.** ☐ Yes ☐ No

6. Have you or any person to be insured under this policy ever been treated for or had symptoms of Dysplasia of the uterus? _____Please describe the level diagnosed. ☐ Yes ☐ No

PLEASE ANSWER QUESTIONS #7 & #8 IF YOU ARE APPLYING FOR THE INTENSIVE CARE UNIT BENEFIT RIDER:

7. Have you or any person to be insured under the Intensive Care Unit Benefit Rider ever been treated for or had symptoms of diabetes or any disorder, abnormality or condition of the brain, lung, liver, or connective tissue? ☐ Yes ☐ No
If Yes, who? _____ **If the answer is Yes, any individual named will be excluded from coverage under this rider.**

8. Are you or any person to be insured under the Intensive Care Unit Benefit Rider currently pregnant? If Yes, who? _____ **If the answer is Yes, any individual named will be excluded from coverage under this rider.** ☐ Yes ☐ No

PLEASE ANSWER QUESTIONS 9–12 IF YOU ARE APPLYING FOR [THE FIRST DIAGNOSIS HEART ATTACK] OR THE INTENSIVE CARE UNIT BENEFIT RIDER[S]:

9. Have you or any person to be insured under [these riders] ever had, ever been treated for, or ever had symptoms of, ever received medical advice for, or taken prescribed medication for uncontrolled high blood pressure? ☐ Yes ☐ No
If Yes, who? _____ **If the answer is Yes, any individual named will be excluded from coverage under [these riders].**

10. **Have you, or any person to be insured under [these riders] ever had or ever been advised to have: any form of heart surgery, coronary artery surgery, or heart related surgery; or an arteriogram, angioplasty, or pacemaker installed, or within the last 6 months, received medical advice or consultation or had medical tests performed (including those during the course of routine check-ups) where the results were other than normal or are still pending?** ☐ Yes ☐ No
If Yes, who? _____ **If the answer is Yes, any individual named will be excluded from coverage under [these riders].**

11. Have you, or any person to be insured under [these riders] ever had, ever been treated for, ever had symptoms of, ever received medical advice for, or ever taken prescribed medication for any disease, disorder or abnormality of the heart or circulatory system (arteries, veins, lymphatic nodes and vessels)? If Yes, who? _____ ☐ Yes ☐ No
If the answer is Yes, any individual named will be excluded from coverage under [these riders].

12. Have you, or any person to be insured under [these riders] ever had, ever been treated for, ever had symptoms of, ever received medical advice for, or ever taken prescribed medication for: myocardial infarction or heart attack, stroke or transient ischemic attack (TIA)? If Yes, who? _____ **If the answer if Yes, any individual named will be excluded from coverage under [these riders].** ☐ Yes ☐ No

Comment [m3]: If the First Diagnosis Heart Attack rider is removed, we will remove the rider from this question and make the word riders singular.

Comment [m4]: If he First Diagnosis Heart Attack rider is removed this variable will become this rider instead of these riders.

Comment [m5]: If he First Diagnosis Heart Attack rider is removed this variable will become this rider instead of these riders.

Comment [m6]: If he First Diagnosis Heart Attack rider is removed this variable will become this rider instead of these riders.

Comment [m7]: If he First Diagnosis Heart Attack rider is removed this variable will become this rider instead of these riders.

I hereby represent that the foregoing answers are recorded as given by me and that the same are true. I represent that all questions on this application were asked and that the answers were properly recorded. I further agree that this insurance applied for shall be subject to the conditions and provisions of the policy and shall not be in force until the application is accepted and the policy issued by the Company. I acknowledge receipt of the Outline of Coverage. I authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, or The Medical Information Bureau to release any records concerning me or my health to United Teacher Associates Insurance Company and its reinsurers. This authorization will be valid for 24 months from the date the authorization is signed. No agent has the right to waive the answer to any question in this application, to pass on insurability, to waive any of the Company's rights or requirements, or to make or alter any contract. I agree that this application shall form a part of any policy issued. The undersigned applicant and agent represent that the applicant has read or had read to him the completed application and he realizes any false statement or misrepresentation therein which is material to the risk or hazard assumed may result in a loss of coverage under the policy subject to the Time Limit on Certain Defenses and legal proceedings. A photographic copy of this authorization shall be as valid as the original.

I understand that the "Effective Date" of this policy will be the date recorded on the policy schedule by our office. It is not the date the application was signed. The policy has a 30-day "waiting period" which begins on the "Effective Date" of the policy.

I KNOW THAT ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD AN INSURER SUBMITS AN APPLICATION FOR INSURANCE CONTAINING FALSE OR DECEPTIVE STATEMENTS MAY BE GUILTY OF INSURANCE FRAUD.

Note to Agent: Is replacement of insurance involved? ☐ Yes ☐ No

Signed at _____ Date: _____
(City and state)

[Agent's Signature _____ Writing Number _____] Read and Signed (√) _____

(Applicant's Signature)

[Agent's Printed Name _____ Agent's License Number: _____ Check Block if Agent Family Business ☐]

Comment [m8]: The agent information is variable so it can be removed on the direct mail application where no agent is involved.

STATEMENT OF VARIABLE DATA

UNITED TEACHER ASSOCIATES INSURANCE COMPANY

[P.O. BOX 26580 •AUSTIN, TEXAS 78755-0580]

Comment [m1]: Address is variable should the company change addresses in the future.

APPLICATION FOR CANCER TREATMENT BENEFIT POLICY

☐ **New Business** ☐ **Reinstatement** ☐ **Benefit Change** PV Case#_____

County Name:		County Number:		Date of Birth Month	Day	Year	Sex	Height	Weight	
Applicant:										
Spouse:								X	X	
Child #1:								Full Time Student	☐ Yes	☐ NO
Child #2:								Full Time Student	☐ Yes	☐ NO
Child #3:								Full Time Student	☐ Yes	☐ NO

Applicant's Address:		City:		State:		Zip Code:	
Payer's Name:		Relationship:		Payer's Address:			
Applicant's Social Security # :				Occupation:			
Beneficiary (full name):		Relationship:		Job Duties:			
Employer's Name:				Employer's Address:			
Home telephone # :	( )	Work telephone # :	( )	Best time to call			

☐ Individual ☐ Single Parent ☐ Family	Premium Payment Mode:	
Cancer Treatment Benefit Policy Daily Hospital Benefit Amount: ☐ $0.00 ☐ $200.00 ☐ $400.00	Modal Premium	$
☐ [*Dread Disease Benefit Rider]*	Rider Premium	$
☐ [*Intensive Care Unit Benefit Rider]* Benefit Amount: **$**_____ per day	Rider Premium	$
☐ [*Cancer Screening Benefit Rider]*	Rider Premium	$
☐ [*First Diagnosis Heart Attack & First Major Heart Surgery Rider]* Benefit Amount: **$**_____	Rider Premium	$
☐ [*Return of Premium Benefit Rider*]	Rider Premium	$
☐ ***Other*** Specify rider type and benefit amount (if applicable:) _____	Rider Premium	$

Comment [m2]: Riders are described as variable as we may elect not to offer a rider in the future. We will not add any riders that are not described in this application.

FOR PAYROLL DEDUCTION:

Group Name:				Enrollment Fee	$
Group Number:		Is this Section #125?	☐ Yes ☐ No	TOTAL PREMIUM	$

1. Is the insurance applied for here intended to replace any existing insurance? If yes, list name of Company and policy number: _____	☐ Yes ☐ No

MEDICAL INFORMATION. Answer all questions and circle the applicable conditions.

2. Have you or any person to be insured under this policy ever had a test to determine if cancer is present where the results are pending or are other than normal? If Yes, who?_____ **Please describe the results**.	☐ Yes ☐ No
3. Have you or any person to be insured under this policy ever been treated for or had symptoms of Internal Cancer, Melanoma, Malignant Growth, Sarcoma, or any type of Cancer, except non-melanoma skin cancer, or had elevated PSA levels greater than 4.0? If Yes, who?_____ **If the answer is Yes, any individual named will be excluded from coverage.**	☐ Yes ☐ No
4. Have you or any person to be insured under this policy ever been treated for or had symptoms of non-melanoma skin cancer? If "Yes", who? _____ **If the answer is "Yes", any individual named will be excluded from all benefits provided by the policy for the treatment of melanoma and skin cancer.**	☐ Yes ☐ No
5. Have you or any person to be insured under this policy ever been treated for or had symptoms of Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or tested positive on an AIDS-related (Human Immunodeficiency Virus "HIV") blood test? If "Yes", who?_____ **If the answer is**	☐ Yes ☐ No

	Yes, any individual named will be excluded from coverage under this policy.	
6.	Have you or any person to be insured under this policy ever been treated for or had symptoms of Dysplasia of the uterus? _____Please describe the level diagnosed.	☐ Yes ☐ No

PLEASE ANSWER QUESTIONS #7 & #8 IF YOU ARE APPLYING FOR THE INTENSIVE CARE UNIT BENEFIT RIDER:

7.	Have you or any person to be insured under the Intensive Care Unit Benefit Rider ever been treated for or had symptoms of stroke, heart disease, heart attack or diabetes; or had any other disorder, abnormality or condition of the brain, heart, lung, liver, connective tissue or circulatory system, including the arteries, veins, lymphatic nodes and vessels (but not including high blood pressure, unless controlled? If Yes, who? _____ **If the answer is Yes, any individual named will be excluded from coverage under this rider.**	☐ Yes ☐ No
8.	Are you or any person to be insured under the Intensive Care Unit Benefit Rider currently pregnant? If Yes, who? _____ **If the answer is Yes, any individual named will be excluded from coverage under this rider.**	☐ Yes ☐ No

PLEASE ANSWER QUESTIONS 9–12 IF YOU ARE APPLYING FOR [THE FIRST DIAGNOSIS HEART ATTACK] OR THE INTENSIVE CARE UNIT BENEFIT RIDER[S]:

9.	Have you or any person to be insured under [these riders] ever had, ever been treated for, or ever had symptoms of, ever received medical advice for, or taken prescribed medication for uncontrolled high blood pressure? If Yes, who_____ **If the answer is Yes, any individual named will be excluded from coverage under [these riders].**	☐ Yes ☐ No
10.	Have you, or any person to be insured under [these riders] ever had or ever been advised to have: any form of heart surgery, coronary artery surgery, or heart related surgery; or an arteriogram, angioplasty, or pacemaker installed, or within the last 6 months, received medical advice or consultation or had medical tests performed (including those during the course of routine check-ups) where the results were other than normal or are still pending? If Yes, who? _____ **If the answer is Yes, any individual named will be excluded from coverage under [these riders].**	☐ Yes ☐ No
11.	Have you, or any person to be insured under [these riders] ever had, ever been treated for, ever had symptoms of, ever received medical advice for, or ever taken prescribed medication for any disease, disorder or abnormality of the heart or circulatory system (arteries, veins, lymphatic nodes and vessels)? If Yes, who? _____ **If the answer is Yes, any individual named will be excluded from coverage under [these riders].**	☐ Yes ☐ No
12.	Have you, or any person to be insured under [these riders] ever had, ever been treated for, ever had symptoms of, ever received medical advice for, or ever taken prescribed medication for: myocardial infarction or heart attack, stroke or transient ischemic attack (TIA)? If Yes, who? _____ **If the answer if Yes, any individual named will be excluded from coverage under [these riders].**	☐ Yes ☐ No

[PLEASE ANSWER THE FOLLOWING QUESTION IF YOU ARE APPLYING FOR THE DREAD DISEASE BENEFIT RIDER:

13.	Have you or any person to be insured under the Dread Disease Benefit Rider ever been treated for or had symptoms of one of the following dread diseases: Addison's Disease, Amyotrophic Lateral Sclerosis, Diphtheria, Encephalitis, Epilepsy, Legionnaire's Disease, Lupus Erythematosus or any connective tissue disorder, Meningitis, Multiple Sclerosis, Muscular Dystrophy, Myasthenia Gravis, Niemann-Pick Disease, Osteomyelitis, Poliomyelitis, Rabies, Reye's Syndrome, Rheumatic Fever, Rocky Mountain Spotted Fever, Scarlet Fever, Sickle Cell Anemia, Smallpox, Tay-Sachs Disease, Tetanus, Toxic Epidermal Necrolysis, Toxic Shock Syndrome, Tuberculosis, Tularemia, Typhoid Fever or Whipple's Disease? If Yes, who? _____ For which _____ **If the answer is Yes, any individual named will be** condition? **excluded from this condition under this rider.]**	☐ Yes ☐ No

Comment [m3]: If the First Diagnosis Heart Attack rider is removed, we will remove the rider from this question and make the word riders singular.

Comment [m4]: If the First Diagnosis Heart Attack rider is removed this variable will become this rider instead of these riders.

Comment [m5]: If the First Diagnosis Heart Attack rider is removed this variable will become this rider instead of these riders.

Comment [m6]: If the First Diagnosis Heart Attack rider is removed this variable will become this rider instead of these riders.

Comment [m7]: If the First Diagnosis Heart Attack rider is removed this variable will become this rider instead of these riders.

Comment [m8]: If the Dread Disease Rider is removed, this question will also be removed.

I hereby represent that the foregoing answers are recorded as given by me and that the same are true. I represent that all questions on this application were asked and that the answers were properly recorded. I further agree that this insurance applied for shall be subject to the conditions and provisions of the policy and shall not be in force until the application is accepted and the policy issued by the Company. I acknowledge receipt of the Outline of Coverage. I authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, or the Medical Information Bureau to release any records concerning me or my health to United Teacher Associates Insurance Company and its reinsurers. This authorization will be valid for 24 months from the date the authorization is signed. No agent has the right to waive the answer to any question in this application, to pass on insurability, to waive any of the Company's rights or requirements, or to make or alter any contract. I agree that this application shall form a part of any policy issued. The undersigned applicant and agent represent that the applicant has read or had read to him the completed application and he realizes any false statement or misrepresentation therein which is material to the risk or hazard assumed may result in a loss of coverage under the policy subject to the Time Limit on Certain Defenses and legal proceedings. A photographic copy of this authorization shall be as valid as the original.

I KNOW THAT ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD AN INSURER SUBMITS AN APPLICATION FOR INSURANCE CONTAINING FALSE OR DECEPTIVE STATEMENTS MAY BE GUILTY OF INSURANCE FRAUD.

I understand that the "Effective Date" of this policy will be the date recorded on the policy schedule by our office. It is not the date the application was signed. The policy has a 30-day "waiting period" which begins on the "Effective Date" of the policy.

Note to Agent: Is replacement of insurance involved? ☐ Yes ☐ No

Signed at _____ Date: _____
(City and state)

[Agent's Signature _____ Writing Number _____] Read and Signed (√) _____
(Applicant's Signature)

[Agent's Printed Name _____ Agent's License Number: _____ Check Block if Agent Family Business ☐]

Comment [m9]: We will remove the agent signature for direct mail

Comment [m10]: We will remove the agent data for direct mail applications